Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HIGHPOINT PAIN CLINIC LP
SUITE 300
800 WEST ARBROOK BLVD
ARLINGTON TX 76015

Respondent Name
Texas Mutual Insurance Company

Carrier's Austin Representative
Box Number 54

MFDR Tracking Number
M4-10-2022-01

MFDR Date Received
December 7, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On August 24, 2009, the denial for authorization of this service was overturned. IRO Case number 21815. On October 6, 2009, the patient received the SI Joint injection. On November 5, 2009, I received partial payment for this service. Code J3301 was paid. The main procedure code, 72275, was denied for payment as, 'claim/service lacks information which is needed for adjudication."

Amount in Dispute: $137.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "An IRO ruled an [sic] sacroiliac joint (SI) injection is medically necessary. Texas Mutual did not appeal that decision. The requestor provided the injection then billed code 72275 as the fluoroscopic portion of the service... The descriptor for code 72275 from the current CPT is "EPIDUROGRAPHY, RADIOLOGICAL SUPERIVSION AND INTERPRETATION.' One can see from this Exhibit that the spinal epidural space is involved with an epidurography and not the SI joint. The IRO decision addressed the need for the SI joint injection, with which Texas Mutual has no dispute. The issue is not Texas Mutual's compliance with the IRO decision but the requestor's persistent failure to offer any rational explanation to resolve the apparent disconnect between the SI joint injection and the epidurography with his initial billing, his request for reconsideration, and now his request for medical fee dispute resolution."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 6, 2009	72275-59	$137.00	$137.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 16 – Claim/service lacks information which is needed for adjudication.
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information
   - 732 – Accurate coding is essential for reimbursement. Services are not reimbursable as billed. CPT and/or modifier billed incorrectly
   - 793 – Reduction due to PPO contract. PPO contract was applied by FOCUS

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Did the requestor bill in conflict with the NCCI edits?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced disputed services with reason codes "45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement" and "793 – Reduction due to PPO contract. PPO contract was applied by FOCUS." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on February 9, 2010 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code § 134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor seeks reimbursement for CPT code 72275 rendered on October 6, 2009. The division completed NCCI edits to identify edit conflicts that would affect reimbursement. No NCCI edits conflicts were identified. As a result, the disputed services will be reviewed according to 28 Texas Administrative Code § 134.203(c).
3. Per 28 Texas Administrative Code § 134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   Per 28 Texas Administrative Code § 134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   The MAR reimbursement for CPT code 72275 is $152.47. The requestor seeks reimbursement in the amount of $137.00, therefore this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $137.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $137.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		October 24, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.